Chapter- Four

DISCUSSION

The major hypotheses are confirmed and discussed. Findings of the present research have been integrated discussed under four major sections. First section of the chapter focuses on interpretations of ANOVA result have been done to determine the impact of deprivation, age and gender groups of youth and adult. Second section of discussion deals with finding of the obtained results on the basis of content analysis. In third section of the chapter, deals with the general discussion on the basis of content analysis and ANOVA results. In fourth section of the chapter, deals with implications of this research and issues for the further researches have been discussed in the light of findings of the present research.

Section-I (AAS)

Interpretation of ANOVA results:

Causal attribution of suicide was assessed in relation to level of deprivation, gender and age. Thus, a 2x2x2 factorial analysis of variance was computed for each factor separately. Results are displayed and reported in chapter III. ANOVA results evinced that attribution of suicide i.e., external and internal factor were influenced by level of deprivation, gender and age. Present findings are reported below:
External Factor:

A close perusal of results (Table-3.2) revealed that external factor was influenced by age groups. The second hypothesis regarding external factor was found to be supported on the basis of present results. On external factor significant main effect of age was found to be significant which revealed that youth participants were more attribute external factor as compared to adults participants (Fig.3.1).

Deprivation x Gender interaction effect were found significant, which revealed that in case of female stronger section participants more attribute external factor than weaker section participants (Fig. 3.2). But reverse pattern were found in case of male participants weaker section were more attribute than stronger section.

Similarly, level of deprivation X Gender X age were found significant, which revealed that in case of weaker section participants youth male participants showed more attribute than youth female participants. But reverse pattern were in case of adult, females participants were more attribute than male participants (Fig. 3.3 a). Whereas in case of stronger section people youth female participants showed more attribute external factor than youth male participants, but reverse pattern were found in case of
adult, male participants were more attribute external factor than female participants (Fig. 3.3 b).

(I) **Internal Factor:**

A close perusal of results (Table 3.4.) revealed that internal factor was influenced by deprivation level, gender and age groups. The second hypothesis regarding internal factor was found to be supported on the basis of present results. On internal factor significant main effect of deprivation level was found to be significant which revealed that participants of stronger section were more attribute internal factor as compare to weaker section participants (Fig. 3.4).

Similarly, main effect of gender was found significant which revealed that female participant more attribute internal factor than male participants (Fig.3.5). Furthermore, main effect age was found significant which evinced that youth participant more attribute internal factor as compare to adult participants (Fig. 3.6).

Level of deprivation X Gender interaction effect denoted that consistent pattern of increment was observed in case of male and female participants (Fig. 3.7). Stronger section of male participants more attribute internal factor than weaker section male. Similarly stronger section of
female participants more attribute internal factor than weaker section participants.

Deprivation x Age interaction effect was found significant, which revealed that in case of adult participants stronger section participants more attribute internal factor than weaker section participants. But reverse pattern were found in case of male participants weaker section were more attribute than stronger section (Fig. 3.8).

Similarly, level of deprivation X Gender X age was found significant, which revealed that in case of weaker section people adult female showed more attribute than adult male participants. But reverse pattern were in case of youth participants, male were more attribute than female participants (Fig. 3.9 a). Whereas in case of stronger section people youth female participants showed more attribute internal factor than youth male participants, but reverse pattern were found in case of adult male participants were more attribute internal factor than adult female participants (Fig. 3.9 b).
The present research provides causal attribution of suicide. In general most of the youths and adults seem attribute cause about the suicide. Although suicide is complex human behavior that cannot easily be predicted, a range of factors has been shown to contribute to it.

Participant’s responses showed suicide main cause depression. Depression can be associated with severe psychological distress; social withdrawal; moodiness; a breakdown in family, personal and social relationships; poor work and academic performance; delinquency; low self esteem; drug and alcohol abuse; eating disorders or attempted suicide. Most young people with depression receive no treatment for it because much of it goes unrecognized and is mistakenly assumed to be normal adolescent ‘acting out’ behavior. Depression is more common in adolescents who have a family history of depression, are anxious, are unable to establish positive social relationships, have a conduct disorder, misuse drugs and alcohol, have concerns about their sexuality, or who suffer negative life events such as bullying, domestic disharmony or physical, emotional or sexual abuse. In a study of psychiatric disorder and risk factors for elderly persons over 65 who had attempted suicide, Draper (1994) found 41 per cent had a major psychiatric disorder (psychotic depression, schizophrenia), 30 per cent had a
minor psychiatric disorder (reactive depression, anxiety, personality disorder), and 29 per cent suffered from organic brain syndromes (dementia, delirium).

Second most frequently suicide cause attributes social conditions. A number of reports over the past three or four decades have pointed to the increase in adverse social conditions such as unemployment, economic hardship and family discord and conflict. With the rise in prevalence of such social and interpersonal problems in the community, it may be the growing rates of depression and suicidal behaviors’ reflect, in part, the increasing presence of these social stressors. International studies indicate societies, communities and all social groups subject to increasing economic instability and unemployment, breakdown of traditional or primary family group structures, greater inter-generational pressures, domestic and interpersonal violence, criminal behavior and secularization increase their risk of suicide mortality. Nonetheless, the exact nature of the association between each of these conditions and suicide mortality remains unclear. Some of the social factors that have been linked to the incidence of suicidal behaviors are outlined below. Despite the limitations of studies on causal inferences, the results of such studies are consistent with the view expressed by writers such as Eckersley in *The West’s Deepening Cultural Crisis* (1993). Eckersley
believes the social conditions prevailing in a country may be a factor in suicide risk, and that changing social and economic structures may contribute to changes over time in rates of suicide and attempted suicide.

Third cause attributes social adaptability. Evidence available to the Task Force suggests impaired social skills and poor social relationships are linked with feelings of hopelessness and helplessness and, in association, they may contribute to suicide. Loneliness and social isolation, particularly when allied with depression, substance abuse and poverty can increase risk of suicide. The Task Force also heard of the particular vulnerabilities of children who have a parent with a mental illness and therefore potential for a disrupted family environment and other pressures. Moreover, evidence supports the view that risk increases when negative life stresses mount in individuals with poor problem-solving skills and deficient coping abilities. Thus, effective problem-solving skills, enhanced self-esteem and strong social/family relationships serve as protective factors by strengthening resilience to stress, and reducing the impact of adverse factors that could exacerbate vulnerability to suicide.

Fourth most frequent cause of suicide relationship. A review of family relations and suicide found a poor relationship with parents to be an important factor (Tousignant, Bastien & Hamel, 1993). Submissions
presented to the Task Force supported this finding, and suggested poor father and son relationships may be a factor requiring increased attention. Precipitating events for suicide may reflect severe conflict with parents, spouse or partner; episodes of family and domestic violence; divorce or loss of a significant relationship; serious illness in the family; loss of a family member through death or separation, or the anniversary of one of these kinds of events. Precipitating events are most often characterized by loss or interpersonal conflict, especially when linked to poorly developed coping or conflict resolution skills. The Task Force heard relationship breakdown or difficulties in establishing positive social relationships were associated with suicidal behavior in young people. A recent study found nearly 75 per cent of suicides occurred within one month of the breakup of a significant relationship, and the rate for men was more than nine times higher than for women (Baume, Cantor & McTaggart, 1996).

People living with chronic diseases may be at greater risk of suicide. Rates of suicide among US AIDS patients in California, New York and Texas have been found to be extraordinarily high (Baume, 1996). They may suffer depression and consider suicide because they are in chronic physical pain, or because they are socially isolated in a way that seriously impairs their quality of life.
Many of the physiological, psychological and social effects of severe alcohol abuse (marriage break-ups, disruption of social ties, impairment of work performance and coping skills, lowering of normal restraints on behaviour, increased impulsiveness, and depression) would reasonably be expected to increase the likelihood of suicidal behavior.

In summary, all these psychological and social factors were contributing significantly to cause of suicide.

On the basis of the findings of this research certain issues have been raised:

(i) How far, these results are in consonance with other research findings?

(ii) To extent deprivation level, age and gender have exercised impact on different factors of suicide attribution of participants?

(iii) Finally, how to extent level of deprivation and age have played role in the manifestation of causal attribution of suicide?

Therefore, an effort was made to discuss these issues in the light of findings of this research as well as other empirical and theoretical evidences.
Empirical validation of findings:

Results of present investigation evinced that influenced of deprivation level, gender and age on causal attribution of suicide. Results also have proved the youth participants show more causal attribution of suicide than the adult participants. These finding have interpreted in relation to other empirical evidences in the following sections:-

(1) Impact of Deprivation on causal attribution of suicide:-

Results obtained on ANOVA analysis revealed that deprivation level impact on attribution analysis of suicide, which were found stronger section people more attribute suicide cause than weaker section people. Present finding have been reported by few numbers of studies. Suicide is more common in areas of high socioeconomic deprivation, social fragmentation and unemployment (Rehkopf & Buka.2006). Increasing income inequality has been linked to increasing suicide rates (De Vogli R. 2009). The greater vulnerability of the disadvantaged people in each community to mental health problems may be explained by such factors as the experience of insecurity and hopelessness, poor education, unemployment, indebtedness, social isolation and poor housing.
(2) **Impact of age on causal attribution of suicide:**

Another finding of this research is that the pattern of attribution of suicide significantly differed among two age groups, i.e., youth and adult respectively. Further study may have deeper strength to explanation a cause of suicide. Youth suicide (i.e., self-inflicted injury resulting in death) and suicide attempts (i.e., self-inflicted injury with intent to die or ambivalent intent) constitute a major public health problem in the United States. Suicide is the third leading cause of death for 15 to 24 year-olds (American Academy of Child & Adolescent Psychiatry [AACAP], 2004; U.S. Centers for Disease Control and Prevention [CDC], 2007). The CDC reported that 2003 had the largest 1-year increase in youth suicide for the preceding 15-year period (2007). **Gould et al. (2003)** report that one study that looked at the socioeconomic status of youth who committed suicide and found no difference, while another study found that low income Latino and Caucasian youth and middle income African American youth had higher rates of suicide than their counterparts in higher income groups.
Youth most at risk of attempting suicide are likely to have recently experienced stressful life events, such as school and work problems, legal problems and interpersonal conflict (Gould et al., 2003). The research cited suggests that parental divorce and strained parent-child relationships may be factors, after accounting for parent and youth psychopathology (Gould et al.). One study cited by Virginia Department of Health’s Suicide Prevention Resource Center reported that 35% of youth suicides occurred the same day those youth experienced a crisis, such as a relationship breakup or an argument with a parent (2006). Youth diagnosed with a mental disorder may be faced with a greater number of stressful events and may also perceive events as being more stressful than those not having a diagnosed mental disorder (AACAP, 2000). It can be difficult to discern whether stress is a result of a mental disorder or is related to events with which youths are unable to cope (AACAP). Family environment and genetic factors are associated with increased risk for suicide among youth. Additionally, family history of suicide and suicide attempts and parental psychopathology are associated with increased risk for youth suicide (Gould et al., 2003).
(3) **Role of gender on causal attribution of suicide:-**

Causal attribution of suicide was also studies in relation to gender. ANOVA results evinced the significant effect of gender on AAS. Findings of this research revealed that attribution of suicide vary among males and females. The rate of suicide among men is 45.46 for every 100,000 persons in 2002. This is in contrast to the same for women are 15.86. The male - female ratio of completed suicides in the year 2002 is 73: 27. In the year 1995 it was 70:30. This shows that in comparison to male suicides, the self-annihilation among females has shown pronounced downward climb (**P.O. George suicides in kerala – an analysis**).